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AUTHOR Maslin, Christine
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ABSTRACT

This paper critically reviews the federally funded Early and Periodic Screening, Diagnosis and Testing (EPSDT) program, and highlights problems in its design and functioning. A prime example of a preventive health program that is commendable in intent but ineffective in actual practice, the EPSDT program's failure was prompted by factors which included: (1) the socio-political climate of the late 1960's; (2) lack of community support for the program; (3) problems in design of the program; and (4) problems in implementation. To prevent the failure of future programs, a comprehensive, strongly preventive approach to physical and mental health care for children is deemed necessary. Implications of national health insurance are discussed. Legislation similar to EPSDT, the Children's Health Assessment Program (CHAP), is evaluated in light of the criticisms and problems of EPSDT, and recommendations for future policy are made. (Author/RH)

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FEDERAL INVOLVEMENT IN PREVENTIVE HEALTH CARE FOR CHILDREN: THE EPSDT EXAMPLE

Christine Maslin
Indiana University

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Author's address: H. L. Smith Research Center, Room 140
Indiana University
Bloomington, IN 47405

GENERAL SUMMARY

This paper critically reviews the federally-funded EPSDT (Early and Periodic Screening, Diagnosis and Testing) program, highlighting problems in its design and functioning. An arguement is made for future programs to take a comprehensive, strongly preventive approach to physical and mental health care for children. Implications for upcoming national health insurance are discussed.

Preventive health care for children, in principle, receives wide support from many segments of our society, yet when translated into practice as a federally-funded program, simplicity has been lost and consensus wanes. The EPSDT program is a prime example of a preventive health program that is commendable in intent but ineffective in actual practice. Its history has been marked by myriad problems, ranging from incomplete and inconsistent implementation at the state and community levels to ambiguity in policy and guidelines at the national level. Although still in operation, the EPSDT program is generally considered to have fallen short of its goals.

A major problem area of EPSDT has been the developmental assessment component. The current confusion in the field concerning assessment of a child's developmental progress stems from the ambiguous wording of the original legislation. The 1967 amendment to the Social Security Act (Title XIX) calls for the detection of "physical and mental defects". Failure by HEW agencies to adequately clarify the meaning of the term mental defect has caused inconsistency in methods of assessment among state screening programs, and has raised broader questions of validity and ethics of mass developmental screening. Controversy among child welfare advocates and child development professionals remains.

(1) Administrative structure. Administrative responsibility has been split between health and welfare agencies causing questions of responsibility for funding, tension between health and welfare personnel, and lack of comprehensiveness in service delivery.

(2) Eligibility for services. Many children needing EPSDT services have not been eligible due to variation across states in eligibility requirements and disqualification because of temporary fluctuations in family income. (This is especially true of children in migrant families with seasonal incomes.)

(3) Availability of services. Many eligible children do not receive on-going EPSDT services because of the difficulty in actually obtaining them. In some communities, families seeking care are required to navigate such a complicated bureaucratic maze that most do not attempt, except for acute medical problems. The original goal of periodic screening has been undermined by an administrative albatross. Moreover, some states have failed to provide even basic, required health and mental health services; subsequent law suits have resulted.

(4) Support from target communities. There is little support for EPSDT among some low-income minority groups (especially Mexican Americans in the Southwest), resulting in little utilization of services by these target groups. Spokespersons for these groups claim that outreach workers and health caregivers are insensitive to their cultural/linguistic/racial background. Moreover, spokespersons argue that the tendency of health care providers to look for and diagnose defects (or disease) rather than strengths affects minority groups disporportionately.

Perhaps the greatest shortcoming of the EPSDT program concerns its general orientation--the detection of physical and mental disease and defects. Up to this point, efforts have centered on detecting physical and mental health problems and providing remedial care where needed--in other words, secondary prevention. What is needed is a shift in orientation to a program that places strong emphasis on primary prevention, that is, the prevention of the occurence of physical and mental disease. Of course, services geared toward detection and diagnosis of disease should not be eliminated, nor should remedial services, however, a general change in program orientation is needed.

Primary prevention can best be accomplished through a program which addresses fully the following guidelines:

comprehensive

community-based

competency orientation

A comprehensive program would provide a broad range of services including not only early screening, diagnosis and treatment, but also expanded outreach and educational services.

A community-based program would draw on representatives of local client groups and health care providers when planning program implementation. Availability of services and acceptance by client groups would be stressed.

By adopting a compentency orientation, psychological and developmental strengths would be highlighted as well as weaknesses and disease. Standards for physical and mental health would be sensitive to cultural and racial differences.

In conclusion, it is not sufficient for policy-makers to concern themselves only with lowering the cost of health care through legislation. Nor is it sufficient to provide states with increased funding for the administration of existing health programs. These actions do not guartee the quality of health care nor do they guarantee adequate continuity of health care. It is time for policy-makers to legislate a comprehensive health care program that takes a strong preventive orientation and is geared toward the needs of our country's poor and minority children. Moreover, full atention must be paid to program design to insure that eligible children do, in fact, receive the health care that they need.

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INTRODUCTION

Preventive health care for children, in principle, receives wide support from many segments of our society, yet when translated into practice as a federally-funded program, simplicity is lost and consensus wanes. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a prime example of a preventive health program which is commendable in intent but ineffective in actual practice. Passed by Congress in 1967 as an amendment to the Social Security Act, the program's success has been questionable. Its eleven-year history has been marked by myriad problems, among them: inconsistencies in implementation at the state and local levels, poor administration at the national level, lack of support from members of target populations, and unresolved issues concerning the nature and method of screening and diagnosis. Not the least of its problems is its lack of visibility. Although still in operation, the EPSDT program is generally considered to have fallen short of its goals.

This paper examines some of the factors that have contributed to the eventual failure of the program. These include (1) the socio-political climate of the late 1960's, (2) community support for the program, (3) problems in design of the program, and (4) problems in implementation. The latter discussion focuses on implementation of the developmental assessment component of the program. In addition, the Children's Health Assessment Program (CHAP), legislation similar to EPSDT which has been considered by Congress, is evaluated in light of the criticisms and problems of EPSDT, and recommendations for future policy are made.

Description of EPSDT

The EPSDT legislation provides for a physical and mental health screening program for children of welfare-eligible families. The 1967 amendment to the Social Security Act (Title XIX, Section 1905 (a) (4) (B)) states that the following is to be provided:

> ... such early and periodic screening and diagnosis of individuals who are eligible under the plan ... to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby as may be provided in regulations of the Secretary.

This legislation requires that every state that operates a Medicaid program provide EPSDT services to all children eligible for Medicaid. EPSDT goes beyond the scope of Medicaid in that it requires not only reimbursement for services but also insurance of the provision of periodic screening, diagnosis and treatment to eligible children (Children's Defense Fund, 1977). States, then, must reinburse for medical expenses and insure the availability of health services to eligible children. In most states, EPSDT is administered through the state's Department of Public Welfare or Department of Social Services (Medical Services Administration, 1977). However, states vary in the type of services and method of delivery (e.g. clinic vs. private practitioner). This results in little consistency across states and fragmentation of administrative responsibility at the federal level (American Orthopsychiatric Association, 1978). Participation in the program is voluntary, and the aim is to maximize participation of eligible families through effective outreach services (Moore, 1978). Lack of participation by members of the target population has been an on-going problem of the EPSDT program. These problems are discussed more fully in the sections on Problems in Design and Practice.

Three types of services are associated with the EPSDT program: screening,

diagnosis and treatment. The following definitions are given in an evaluation report of EPSDT by the Children's Defense Fund (1977):

Screening is defined as "... the use of quick, simple, relatively inexpensive procedures to ... separate ... apparently well persons from those who probably have a disease or problem requiring further attention" (p. 12).

Diagnosis is "... the determination of the nature and cause of a disease or abnormality. [It] has two major purposes: (1) to confirm or disprove the positive results of a screening test; and (2) to develop a plan for dealing with a disease or abnormality if one is ... found."

Treatment is "... all of the services needed to control and hopefully cure a health problem."

Specifically, the services required by EPSDT include the following (based on the report of the Children's Defense Fund, 1977, pp. 12-13):

(1) Availability of and payment for screening services within sixty days of request. Recommended procedures are:

- Health and developmental history
- Height, weight, and other measures of physical growth
- Developmental assessment
- Unclothed physical inspection
- Ear, nose, mouth, and throat inspection, including assessment of dental condition
- Vision testing
- Hearing testing
- Anemia testing
- Sickle cell test
- Tuberculin test
- Urine test
- Lead poisoning screening

- Assessment of nutritional status
- Assessment of immunization status, and
- Other tests as appropriate (e.g., blood pressure, chest X-ray, pinworm slide)

(2) Availability of and payment for diagnostic services for individuals in need, as determined by screening results.

(3) Availability of and payment for needed treatment, subject to the amount, duration and scope covered by the state Medicaid plan. In addition, states are required to make available and pay for services associated with treatment of visual or hearing defects and any dental care necessary for relief of pain, and infection, or restoration of teeth.

(4) An outreach program to inform eligible families that services are available and where and how they can be obtained.

(5) Development of contractual agreements with existing facilities and practitioners in the state for the provision of EPSDT services.

(6) Availability of transportation to and from services.

Financing for EPSDT is through Medicaid, so states are reimbursed for screening, diagnosis and treatment costs. The percentage of reimbursement varies by state (from 50% to 78%) depending on the state's per capita income (Children's Defense Fund, 1977). Administrative costs are reimbursed at the 50% level; outreach and follow-up costs at 75% (Children's Defense Fund, 1977).

EPSDT as a Prevention Program

Because of the emphasis on early identification and treatment of physical and mental problems, the EPSDT program can be classified as secondary prevention, according to Caplan's (1964) definition. A main goal of EPSDT is to identify physical, mental or developmental problems at the earliest possible point and to provide treatment to minimize the severity of a problem. As EPSDT currently exists, the emphasis is on detection of mental and physical "defects" at an individual level. In other words, EPSDT adheres to the traditional medical (or deficit) model. Following this model, as many supposed prevention programs

do, the source of mental health problems is considered to be intrapsychic and independent of environmental stress (Heller and Monahan, 1977). This tendency to "blame the victim" is increased when clients are culturally or racially different from the health workers, as is the case, for example, with Mexican-American children in EPSDT (Gibson, 1978). Coleman (1978) argues that the assumptions associated with the medical model are especially inappropriate when applied to developmental assessment. This point will be discussed in more depth in the section entitled Problems of EPSDT in Practice.

A program which follows a deficit model is limited in its effectiveness because it does not provide primary prevention at the community, rather than individual, level (Heller & Monahan, 1977). To provide primary prevention at the community level would require a shift in thinking from the deficit orientation to a focus on competencies and strengths. A competency orientation, as an alternative to the deficit model, would have important implications for the type of services to be provided by a comprehensive children's health program. In order to reflect a shift to more of a competency orientation, a preventive health program for children might also emphasize the development of physical, psychological and developmental strengths, while continuing to screen for weaknesses. A program of this sort might provide educational or nutritional programs, for example, and intervention would occur before symptoms appear (e.g., pre- and post-natal care). The level of intervention would shift from individual to community. At present, EPSDT seems to have focused on the individual level, without systematically seeking community support or involvement of community members.

This limited focus may explain, in part, both the mediocre success in improving the health status of eligible children and the lack of community-based support for the program. Several critics of the EPSDT program (American

Orthopsychiatric Association, 1978; Bower, 1978b; Gibson, 1978; U.S. Department of Health, Education and Welfare, 1977) have called for a shift to a competency orientation. Such a shift would most likely benefit target children by highlighting individual strengths and perhaps allowing the acceptance of culturally or racially different behaviors as competencies rather than deficits.

SOCIO-POLITICAL FOUNDATIONS OF EPSDT

History of Health Care Policy for Children

An examination of the history of children's health policy in the United States shows a somewhat disjointed, piecemeal approach. G. Y. Steiner (1976) observes that most federal actions on child health issues are characterized by "...political accidents and back-door approaches rather than rational responses to rational proposals" (p. 206). A number of legislative and executive moves have been heralded as cornerstones in the foundation of a national health care policy for children. Most notably are (1) the four programs for children (Aid to Dependent Children, Child Welfare Services, Maternal and Child Health Services, and Crippled Children's Services) established by the passage of the Social Security Act in 1935 (Steiner, 1976), and (2) the EPSDT program, "potentially the most comprehensive child health care program the government had ever undertaken" (Foltz, 1975, p. 35). None are a result of careful design or planning, nor do any represent the implementation of a national policy on child health.

Despite considerable legislative effort, at the end of the 1970's we find the federal government void of a comprehensive children's health policy and with little prospect for one in the future. As a result, current federal activity concerning children's health is marked by isolation of efforts, often with duplication, and little interprogram coordination. This condition is no doubt exacerbated by fragmentation of administrative responsibility for children's health programs. Currently, four agencies within the Department of Health, Education, and Welfare administer research or service programs concerning child health: the National Institute of Child Health and Human Development, the Health Care Financing Administration, the Health Services Administration, and the Bureau of Education for the

Handicapped. Moreover, Congressional responsibility is similarly fragmented with no less than six Senate and House subcommittees, in 1976, addressing child health concerns (Steiner, 1976).

One piece in the collage of health services for children is the EPSDT program. As this country's single largest federal health care program for children (Children's Defense Fund, 1977), EPSDT had the potential to markedly improve inadequate patterns of health care for low-income children. However, lack of adequate legislative forethought concerning guidelines for implementation, types of services to be offered and, eligibility for such services (Foltz, 1975) has resulted in myriad problems in the actual implementation of the program. A detailed discussion of these problems can be found in the section entitled "EPSDT in Operation: A Critical Review". The present section will discuss the socio-political climate surrounding the legislation of the EPSDT program.

Rationale for EPSDT

EPSDT was initiated in the late 1960's--a product of the social reform movement that accompanied the Civil Rights Movement and President Johnson's Great Society programs. According to Foltz (1975), the time was ripe for a children's comprehensive health care program, especially for those not receiving health services through the private sector. Various health care programs were already being offered at the federal, state, and local levels, and evidence was accumulating in support of the beneficial effects of preventive services (Foltz, 1975). A logical next step was for the federal government to provide these services in a comprehensive fashion.

Yet, the rationale and subsequent legislative history of the EPSDT program was not quite so straightforward. EPSDT attracted little Congressional attention and seems to have been developed in the absence of a political or social mandate

and without a clearly identified rationale. Steiner (1976) comments that the legislative and administrative history of EPSDT "... epitomize(s) back-door policymaking" (p. 221). Hence, the explanation of provisions that accompanied the proposed EPSDT legislation included no estimate of cost. No statement of the administrative ramifications (such as, which federal agency would administer the program, and how states' services would be evaluated), which would accompany EPSDT, was made. (Although a health screening program, EPSDT is designed for children of welfare-eligible families so it has been jointly administered, not without problems, through both health and welfare agencies at both the federal and state levels.) The questions of type and extent of services and eligibility for such services were not addressed (Foltz, 1978). The unaddressed questions originally surrounding EPSDT would repeatedly prove to be obstacles to implementation in the years to come. The "ambiguity" described by Foltz (1975) that accompanied the early proposals for EPSDT remains unresolved today.

Legislative Foundations of EPSDT

The origins of EPSDT can be traced back to a 1966 program analysis report from the Secretary's Office of HEW (Foltz, 1975). In that report, three possible programs were proposed; each varied in specific intent and recommended funding level but they shared the general intent of lifting a burden from society by preventing handicapping conditions in children. This initiative was followed up by a Presidential recommendation that funding for health care for needy children be doubled to $221 million and that the number of children being treated under the Crippled Children's program be doubled to one million (Foltz, 1975). Several days later, legislation, which incorporated the President's recommendations, was introduced into Congress.

EPSDT's Legislative Structure

Three amendments to the Social Security Act (H.R. 5710), one of which was to Title V (Crippled Children's program) and two of which were to Title XIX (Medicaid), comprised the provisions for the EPSDT program. The major amendment, which was to Title XIX, provided the backbone for the EPSDT program and called for early physical and mental screening, diagnosis and treatment. The other amendment to Title XIX called for cooperation between Title XIX services and the existing health programs of Title V (the Crippled Children and Maternal and Child Health programs). This amendment included agreements for provision of services and reimbursement for services between Title XIX (welfare) and Title V (health) agencies. Concerning the specific ways in which this cooperation would occur, the legislation stated that the Secretary of HEW would write regulations clarifying the scope of the relationship at a later date (Foltz, 1975). These regulations, along with other regulations and guidelines for implementation, did not appear until 4 1/2 years later, and only after pressure from welfare rights groups (Children's Defense Fund, 1977; Foltz, 1975). The third EPSDT amendment, an amendment to Title V (Crippled Children's program), required more comprehensive preventive efforts against crippling conditions and increased authorizations for the program from $55 to $65 million. This replaced the weaker language in the earlier Crippled Children's provisions which only required identification of crippled children (Foltz, 1975).

As may be evident already, there appears to be considerable overlap between two of the EPSDT amendments (the amendment to Title XIX and that to Title V). Although it is not clear whether the overlap is intentional or merely oversight on the part of legislators, an attempt will be made here to distinguish between the two amendments.

Title XIX. Title XIX concerns Medicaid, which as a welfare program

provides financial reimbursement for health services to eligible individuals. The major EPSDT amendment to Title XIX concerns expansion of the scope of health care services covered by Medicaid. It does not speak, however, to the quality of that care or to the method by which that care is delivered (through public or private means). These specifics are individually determined by each state that offers a Medicaid program.

Title V. In comparison, the programs of Title V are health-related and, although housed at the federal level in the Children's Bureau until 1969, are usually administered by health officials at the state level (Foltz, 1975). The EPSDT amendment to Title V concerns the provision of expanded health care services, specifically earlier identification of defects or chronic conditions than was previously required and provision of necessary treatment to ameliorate such conditions.

In summary, Title V is concerned with the delivery of health services (specifically, expansion of the number of services and an increase in that availability) while Title XIX provides financial reimbursement for such services. This results in a split of administrative responsibility for EPSDT between welfare and health agencies, not only at the federal level but within each state. Ironically, the third EPSDT amendment (to Title XIX) was designed to facilitate cooperation between these two types of agencies, yet the administrative ambiguity that has plagued EPSDT since its implementation has not been resolved, nor have HEW officials provided direction in remedying this condition.

EPSDT's Legislative History

Three phases comprised the legislative history of EPSDT (from Foltz, 1975): as H.R. 5710 when it was discussed before the House Ways and Means Committee in 1967; as H.R. 12080 when it emerged as a Ways and Means Committee

Report later in 1967; and in hearings before the Senate Finance Committee two months later. Throughout, the issues of program cost and administration were discussed while the questions of scope of services and eligiblity were ignored (Foltz, 1975). The question of funding was intimately tied to the confusion over whether EPSDT was a Title V or a Title XIX program. This question and those concerning scope of services and eligibility were not resolved at the end of the second phase, when the 1967 amendments to the Social Security Act were passed by the House. During Senate hearings, the EPSDT amendments received only scant attention. One witness, from the American Academy of Pediatrics, recommended an amendment that would require, rather than merely provide for, cooperation between state agencies administering Crippled Children's programs and those administering Title XIX programs (Foltz, 1975). No such amendment was added. Foltz reports that Congress "... retained the more ambiguous wording of the amendment that state Title XIX agencies provide for 'entering into agreements' with Title V... agencies" (1965, p. 49).

For a program of such scope and fiscal importance, it is evident that Congress gave EPSDT only casual attention (Steiner, 1976). Rather than dealing with the complex issues that the EPSDT legislation raised, Congress has been accused of approving the legislation of good intentions (Steiner, 1967, p. 223) and ignoring the meat of the matter. Steiner partly attributes EPSDT's superficial treatment to the fact that the EPSDT amendments lacked a Congressional sponsor. As "no congressman's baby" (Steiner, 1967) EPSDT lacked the attention needed to nurse it through Congress and insure prompt and effective implementation after it became law. Instead, a 4 1/2-year period passed before initial regulations were issued. During this time, confusion arose concerning which agency should issue the regulations. When the regulations were released, numerous

protests by states over the likely cost of the program and scope of services to be provided followed in their wake (Foltz, 1975; Steiner, 1976).

Final guidelines were not issued until 1972 and full implementation did not take place until July 1973, almost six years after becoming law. The federal mandate to implement EPSDT was not without its problems. Even before July 1973, it was evident that most states would not comply with HEW's regulations and guidelines (Foltz, 1975) nor would the implementation that did occur be free from problems. Foltz reports that "... only half the states could be said to be implementing the program state-wide without problems" (1975, p. 35). It was not until this implementation stage that the full extent of EPSDT's ambiguity became apparent.

EPSDT IN OPERATION: A CRITICAL REVIEW

Despite the tremendous promise that the EPSDT program held (Children's Defense Fund, 1978), its numerous problems in design and implementation have prevented it from becoming the answer to health problems for the poor that it was hoped to be. This section reviews some of the stumbling blocks to success, including problems in design and in practice of the EPSDT program. Unfortunately, realistic solutions are not readily available for most of the issues raised. It seems that EPSDT's faults are easily spotted but not so easily remedied.

Problems of EPSDT in Design

Many of the problems or inadequacies of the EPSDT program can be traced back to the lack of a clear statement concerning what EPSDT should and could do. The 4 1/2-year lag between passage of the legislation and the issue of final regulations was accompanied by confusion and lack of agreement within HEW about where to place administrative responsibility for EPSDT. When the decision was made to house EPSDT in the Medical Services Administration (MSA), which is part of the Social and Rehabilitation Service, a number of problems arose.

Administrative Fragmentation

One problem concerns administrative fragmentation of the program. Although housed in a welfare agency, EPSDT services are health related. The staffs of welfare agencies, from the federal level down to local agencies, were not experienced or trained to design and implement health services (Children's Defense Fund, 1977). Moreover, housing a health-related program in a welfare agency caused tension between health and welfare personnel at the federal and state levels (Foltz, 1975). The issue of responsibility for funding,

at the state level especially, was a major issue. Clarification was needed by Title V (health) and Title XIX (welfare) agencies concerning reimbursement for funds--for which services provided by a Title V agency would reimbursement be made by the state's Title XIX agencies? Statements from the MSA were ambiguous and sometimes contradictory to earlier statements, adding to the confusion (Foltz, 1975). The design of EPSDT as a state-administered grant-in-aid program and the split of responsibility for implementation between health and welfare agencies resulted in poor coordination and lack of comprehensiveness of services at the local, state and federal levels. Systematic attention to administrative structure must be paid in the future to assure a comprehensive health care program.

Scope of Services

A second problem of design that has plagued EPSDT concerns the scope of services to be provided. The MSA originally called for states to offer any screening, diagnosis, and treatment services necessary--regardless of the limitations imposed on Medicaid services by existing state plans (Foltz, 1975). At the time, states varied widely in the scope of services they provided through Medicaid. Some states offered only the federally required services while others extended Medicaid coverage to a full range of services (Foltz, 1975). Foltz (1975) reports that states objected vigorously to this new requirement, primarily because of the cost involved. When MSA reissued final regulations, the scope of services to be provided was significantly curtailed, requiring states to provide only EPSDT services that fell within the limits of each state's existing Medicaid plan (Foltz, 1975). This resulted, of course, in different services being provided in different states, adding to the lack of comprehensiveness of the EPSDT program.

Eligibility for Services

Eligibility for services and continuity of care is a third problem area for EPSDT. Eligibility for EPSDT is currently linked to a family's financial status and eligibility for the state's financial assistance programs. Criteria vary from state to state and a family's status can change if a parent's work status changes or the family income rises (Children's Defense Fund, 1977). A change in a family's eligibility status means that the children in these families drop in and out of the EPSDT system, resulting in lack of continuity of care. This problem is especially pertinent for children of migrant workers or workers with other seasonal or intermittent employment. Their income may vary such that during months of unemployment they meet eligibility criteria but lose eligibility status when work begins again. A child in such a family may be screened and have a diagnosed problem, start on treatment, then have it interrupted by loss of eligibility. Most likely, a family of this type would not have sufficient resources to pay for continued treatment in the private sector. It has been suggested that to better assure continuity of care, eligibility for EPSDT services should continue for six months after the family's change in financial status.[1] This change would alleviate the lack of continuity problem for at least some children.

Problems of EPSDT in Practice

Numerous problems associated with the implementation of EPSDT are discussed in recent literature. Most of the discussion focuses on three problems: (1) availability of services, or outreach; (2) community support; and (3) the developmental assessment component of EPSDT.

Availability of Services

The ability of state EPSDT programs to reach target populations has been embarrassingly inadequate. According to an evaluation by the Children's Defense Fund (1977), which represents the most comprehensive review of the program to date, EPSDT has reached only a small percentage of the children it was designed to serve. Of those children who qualify for EPSDT services (according to state eligibility criteria), only 15% in 1975 (1.4 million) and 17.2% in 1976 (1.7 million) of eligible children were screened[2] (Children's Defense Fund, 1977). These numbers do not include children who may be medically needy but do not qualify for Medicaid in their state. Moreover, it appears that many families use Medicaid funds for treatment of acute medical problems or emergencies only. The Children's Defense Fund (1978) reports that "rarely were its [EPSDT's] resources used to prevent or treat children's health problems early in their course" (p. 79). Either parents are not aware that screening and early treatment services are available or they are aware but choose not to use these services. There are data to suggest that both of these factors are operating (Children's Defense Fund, 1978; Gibson, 1978; U.S. Department of Health, Education and Welfare, 1977).

Part of the problem of inadequate outreach may be due to the shift in states' role as a result of the EPSDT regulations. The requirement that states provide health services and inform eligible families of these services means a change by state agencies to a more active role in delivery of services than was formerly required (Children's Defense Fund, 1978). With no federal guidelines on how to expand outreach services, it is not surprising that many states were reluctant and/or inadequate in providing expanded services.

Some states have responded to the EPSDT changes with resistance (Foltz,

1975; Children's Defense Fund, 1977). In no fewer than fifteen states (including Indiana) law suits have been filed concerning inadequate provision of EPSDT services (Children's Defense Fund, 1977). As discussed earlier, states vary in the scope of services provided. Some offer screening services through public health departments while other states rely upon the private sector to fulfill the EPSDT screening requirements. Certainly, availability of services to low-income children is going to be more restricted in those states using private physicians only than in states which include public clinics.

Community Support

A second problem area which has impeded implementation of EPSDT is lack of community support, especially lack of trust and involvement of the community members for which EPSDT was designed. One group in which there is little support for EPSDT is the Mexican-American (or Chicano)[3] population (Gibson, 1978). Gibson carefully reviews and discusses the concerns of Chicanos in regard to implementation of the EPSDT program. From the perspective of many Chicanos, EPSDT has been insensitive to their needs and their cultural and language differences. Gibson seems to be referring to a disparity of class and culture between clients and caregivers. This is most likely a result of the lack of input from potential client populations in the planning stages of EPSDT.

Gibson (1978) also points out that mental health services have traditionally been more insensitive to Mexican-Americans' needs than have health services. Chicanos, according to Gibson, are underrepresented in populations served by mental health programs, due primarily to the irrelevancy of services typically provided. Dissatisfaction with services has arisen, in part, due to the traditional deficit model that characterizes many mental health programs, EPSDT not excluded. This model is inappropriate for the Chicano population because

it "... focuses on personal deficiencies of clients and completely ignores social, economic, and political forces impinging on them, which adversely affect their emotional well-being" (Gibson, 1978, p. 101). Use of this model results in the use of diagnostic and treatment procedures that are "... ethnocentric and irrelevant to the Chicano experience" (Gibson, 1978, p. 105). These serve, Gibson asserts, to reinforce stereotypic thinking about Chicanos. These criticisms also hold for other racial or ethnic minority groups who are potential clients for EPSDT.

To overcome some of these problems, Gibson (1978) suggests some changes in the implementation of EPSDT. For outreach services, workers should be bilingual-bicultural and trained to interpret the EPSDT program to families. Workers such as this have been successful in southwestern areas of the United States in involving a substantial number of families (Gibson, 1978). In addition, health caregivers should be bilingual-bicultural if possible, or at least sensitive to the realities of Chicano life, and services should be located within the Chicano community. Gibson emphasizes the point that mental health services should not stifle cultural differences but rather, recognize and respect them.

The recommendations made by Guadalupe Gibson (1978) concerning Chicanos can easily be applied to other minority groups. By recruiting and training members of various minority groups to deliver outreach and health services, within their own communities, the view by (minority) client groups of health-care practitioners as trustworthy and sensitive to needs will be increased. In addition, problems of cultural and linguistic differences between caregivers and clients will be minimized.

Yet the problems of lack of participation and support of EPSDT by

minority groups is more complex than just lack of similarity between health caregivers and target client groups. The EPSDT program has, up until now, taken an individually-centered view of health and mental health problems without regard for the role of environmental factors. By switching to the view that many health or mental health conditions are closely intertwined with an individual's social and physical environment, a preventive health care program such as EPSDT would surely meet with more success. Interventions would be community-centered as well as individually-centered. Specific changes might include the identification and use of cultural health-care practices, within EPSDT programs, and recognition of cultural or racial standards for behavior and mental health.

Developmental Assessment

The provision of developmental assessment services has probably been the most problematic aspect of EPSDT. There is general agreement among those who have investigated EPSDT that the developmental review process, as it currently exists, is unsatisfactory. The report by the Children's Defense Fund (1977) provides an example of the dissatisfaction voiced. Children's Defense Fund investigators report that, as a result of field visits to five representative counties administering EPSDT, "... in practice EPSDT was not effectively catching, referring and treating children with developmental problems" (1977, p. 171). A number of authors have discussed the factors which have contributed to the shortcomings and ambiguity surrounding developmental review. Discussion has focused on the following aspects of the problem: (1) definition of developmental assessment and selection of assessment instruments (Children's Defense Fund, 1977 and 1978; Coleman, 1978; Moore, 1978; U.S. Department of Health, Education and Welfare, 1977), (2) training of practitioners to administer assessments (Children's Defense Fund, 1977 and 1978), (3) labeling and confidentiality (American Orthopsychiatric Association, 1978; Coleman, 1978;

Moore, 1978; U.S. Department of Health, Education and Welfare, 1977), and (4) involvement of parents in the assessment process (Children's Defense Fund, 1977; Gibson, 1978; Moore, 1978).

Definition of Developmental Assessment

There is disagreement in the field of child development concerning definitions of developmental screening and developmental assessment (Meier, 1973). The lack of consensus in the profession is reflected in the developmental assessment component of EPSDT in a number of issues. First, there is wide variation across states in (1) the definition of what constitutes developmental review and (2) in the instruments used and procedures followed to assess development. Some states (e.g., Michigan) require that a particular developmental test be used for all EPSDT screenings, while in other states, use of a standardized test is optional and informal observations of the child's development are used to determine developmental status (Children's Defense Fund, 1977).

This state of affairs is due, in part, to a second but related issue--the appropriateness of developmental tests for the population to be screened. Since EPSDT-eligible children are from low income families, many are also from cultural, racial and/or linguistic backgrouns different from the population on which the assessment instruments were standardized. Questions of validity come into play here, raising issues about test content and format analogous to the current debate on cultural bias in intelligence tests. Questions of predictive validity are always of concern for developmental assessments performed during infancy and early childhood (Anastasi, 1976, p. 333). Even the most psychometrically-sound tests of early development (e.g., the Bayley Scales of Infant Development) have only moderate success in predicting later performance after age 2 and virtually no predictive validity prior to this age

(e.g., Anastasi, 1976, p. 333; Honzik, 1976, p. 67-7[illegible]). When applied to a population of minority children, the problem becomes more complex. Most developmental tests are especially plagued with validity problems in relation to testing minority or culturally-different groups (Coleman, 1978; Lewis and McGurk, 1973; Meier, 1973). The Denver Developmental Screening Test (DDST), the most frequently used developmental screening test in the EPSDT program, has received considerable criticism for the inappropriateness (i.e., cultural and/or racial bias) of some items for children from minority backgrounds (Children's Defense Fund, 1977).

Thirdly, the rationale used by states for selecting a certain development instrument(s) is not necessarily based on that instrument's psychometric qualities or cultural/racial/linguistic appropriateness. States may have chosen certain tests for practical reasons, such as ease of administration or amount of training needed before administering the test. The frequently used Denver (DDST) has advantages; it can be administered by a paraprofessional relatively quickly and with very little prior training (Children's Defense Fund, 1977). However, the disadvantages of the Denver are cause for question of its continued use. Criticisms include its lack of sensitivity to individual variation in development within the normal range, inappropriate and too broad age ranges for many items, and omission of key concepts in adaptive behavior (Frankenburg and Dodds, 1967).

A fourth issue concerns criticism of developmental assessment instruments in use by EPSDT programs for their inability to assess adequately the complexity of development (e.g., Children's Defense Fund, 1977). In an effort to screen quickly using paraprofessional or volunteer staff, many of the current screening instruments assess development at only a superficial level. Moreover, critics of standardized assessment instruments maintain, that for minority groups,

standardized tests yield inaccurate and biased information (Mercer, 1975) and some have concluded that their use with minority children should be restricted if not stopped altogether (e.g., Children's Defense Fund, 1977, p. 180). The ramifications of such a position are disheartening to one who would like to both improve the quality of and expedite routine developmental assessment for our nation's poor children. The author's of the Children's Defense Fund report (1977) have taken the somewhat over-reactionary stance of calling for any screening/assessment instrument, standardized or not, to cease being used within EPSDT programs.[4] This action would leave screeners not only without an acceptable standardized test but fumbling among themselves to devise an in-house, inferior (most likely) version of developmental criteria. This is clearly an unacceptable alternative. In addition, screening is often fragmented (American Orthopsychiatric Association, 1978) due in part to the maze of agencies typically providing health services in a community. An argument for comprehensive health screening and health care includes centralization of services to eliminate fragmentation.

Training of Practitioners

Crucial to the validity of developmental screening and assessment is the skill and sensitivity of the screener/assessor. A competent examiner will not only be skilled in administration of the assessment instrument but will also be able to readily establish rapport with the child and parent(s), if present, in order to encourage communication and gain maximum information. Often times, a prerequisite to such communication is competence in a second language (other than standard, white English) and familiarity with the child's cultural milieu.

The review of EPSDT by the Children's Defense Fund (1977, p. 173-174) found

training of health care personnel was often inadequate, especially concerning developmental review and serving non-English-speaking clients. The implications for training future health care providers are clear.

Labeling and Confidentiality. The problems associated with labeling are important issues in EPSDT's developmental review. Again, the inappropriateness of the medical model can be seen. Developmental problems do not lend themselves to one- or two-word labels, the form which many medical diagnoses take (American Orthopsychiatric Association, 1978). The fear of inaccurate and unjustified labeling arises and we are reminded of the resulting detrimental effects (e.g., Levine & Graziano, 1972; Rosenthal & Jacobsen, 1968). Moreover, the incidence of both false positives (incorrectly detecting the presence of a certain disease, or in this case, developmental problem) and false negatives (failing to detect the presence of a certain disease or developmental problem) would be expected to increase when culturally- or racially-biased assessment instruments are used for screening minority populations. Several authors (e.g., Children's Defense Fund, 1978; Coleman, 1978; Gibson, 1978) have recommended that EPSDT adopt a developmental review procedure that uses instruments that do not result in a label and are appropriate for the population being assessed.

Confidentiality is another important issue in EPSDT developmental review. For children in EPSDT, detailed records are kept not only of the child's health history and screening/assessment results but also detailed information about the family which is highly confidential (American Orthopsychiatric Association, 1978). Despite guarantees that such information is kept confidential, it is important that mechanisms be established to protect each EPSDT child's (and family's) right to privacy. At present, such mechanisms do not exist in EPSDT programs on a universal basis.

Involvement of parents. In many programs, EPSDT screenings are performed

without the child's parent(s) present (Children's Defense Fund, 1977). This often happens because screenings are done at a time when parents are unable to attend. Even when parents do accompany their child to the screening, very few programs include the parents actively in the screening process; parents are typically not interviewed for information about their child's health or development (Children's Defense Fund, 1977). The result is minimal involvement of parents who should be maximally involved in all aspects of their child's care.

The arguement for higher levels of parental involvement in the screening and developmental assessment of children is obvious. Parents are an important source of information concerning their child. In general, they know their child well and there is evidence that they are accurate at identifying abnormalities in their child'd development (e.g., Hobbs, 1974, p. 94; Wagner, 1976, p. 5). Moreover, it seems highly likely that parents who have been actively involved in the diagnosis-assessment process, and are aware of the results, are more likely to take a responsible role in the follow-up care of their child than parents who have not been involved. To assure maximum opportunity for parental involvement in the assessment of their child, efforts should be made to schedule assessments when parents can attend, to provide transportation when needed, and to use linguistically-same and culturally-same health care providers.

Recommendations for developmental assessment. Since no requirements currently exist concerning the process of developmental review in EPSDT, what recommendations can be made? Beatrice Moore (1978), presently director of the EPSDT office, suggests a three-stage process which would improve current EPSDT practices. These stages include: (1) a review of standard biological dimensions associated with a pediatric exam and a parent report concerning the child's functioning; (2) a structured obser-

vation of the child's functioning, perhaps using broad screening devices; and (3) a detailed review of four domains of development (biological, psychological, family and environmental/socio-cultural). These stages are sequentially ordered; review at stage 2 (or 3) would not occur unless the results of the review at stage 1 (or 2) indicate further assessment. Not until stage 3 would a standardized test be used, if at all. These recommendations would improve on current EPSDT practice by, first, assuring some consistency in procedure across states, and secondly, by discouraging the tendency to label children based on the results of a quick review.

An alternative recommendation has been made by the authors of the Children's Defense Fund report (1977): that developmental screening as a separate component be removed from the EPSDT program and that developmental assessment of EPSDT-eligible children be carried out within the context of routine pediatric exams. Whether this service will be provided at a sufficient level by community health agencies, or whether clients will need to rely on existing private services is not clear.

Although the Children's Defense Fund recommendation is intended to alleviate some of the problems associated with mass developmental screening (as discussed above), it seems to be based on an unrealistic and somewhat reactionary assumption: that low-income children can (or will) receive adequate health care through traditional pediatric services. A number of potential problems with this assumption can be raised. First, the question of whether adequate pediatric services (including developmental review) are available to and will be used by low-income clients must be addressed. A review sponsored by HEW, of the developmental assessment component of EPSDT cited the unwillingness of private health professionals to help with public health problems as a major reason for the lack of success of EPSDT (U.S. Department of Health, Education and Welfare, 1977). Even if there is a change of attitude among private health professionals, the question

of whether minorities will use these services remains. There is a paucity of minority-group members in health-care occupations, yet minorities prefer and trust health caregivers of the same racial/cultural background, and seek out services provided by them more readily than those provided by racially- or culturally-different caregivers (Gibson, 1978).

A closely-related question, which will not be discussed in depth here, concerns the qualifications of most traditionally-trained physicians to conduct a thorough and appropriate assessment of a child's development. Knobloch and Pasamanick (1974, pp. 382-387) argue that training in developmental diagnosis needs to brought more squarely into programs of pediatric education. The implication is that training in child development has traditionally not received adequate emphasis in medical school curricula.

Secondly, the extensive and sometimes overwhelming bureaucratic maze surrounding local health care services (for example, see Children's Defense Fund, 1977, pp. 147-148) makes many of these services virtually inaccesible to minorities. Because they rely on federal aid programs (such as EPSDT or Medicaid) for payment for health services, low-income families are restricted to using physicians who will see Medicaid clients (Children's Defense Fund, 1977). It is easy to understand why a low-income family would conclude that for minor health problems or routine preventive care, the effort to obtain health services is not worth the result.

A third problem concerns the reactionary nature of the Children's Defense Fund recommendation. A switch to developmental assessment within standard pediatric exams (as the Children's Defense Fund recommends) would result in a perpetuation of the medical model--that is, viewing problems as individually-centered and ignoring the need for more community-centered interventions. As discussed earlier, a switch to a community-based view of health and mental health would allow the consideration of environmental, cultural,

and racial factors in diagnosis treatment and prevention.

In summary, the Children's Defense Fund recommendation may be a viable alternative only if a number of changes in our health care system are made. The availability of services must be improved, the number and types of services (covered by federal reinbursement programs) expanded, and modifications to meet minority needs made, or the Children's Defense Fund recommendation is apt to make little impact on the quality of health care for low-income children.

Summary of EPSDT in Operation

There appears to be consensus concerning the lack of success of the EPSDT program. From its genesis, EPSDT encountered complex political and practical issues, yet the absence of systematic consideration of these issues left most of them unresolved. The result was a program with good intentions but little effectiveness in implementing them.

What contributions, if any, has EPSDT made? A joint review of the program by the American Association of Psychiatric Services for Children and the U.S. Department of Health, Education and Welfare (1977) stated that EPSDT's significant contribution was "...to uncover the present health system's inability to provide comprehensive and continuous health services for poor children, even given a financing mechanism" (U.S. Department of Health, Eduation and Welfare, 1977, p. 44). It is disheartening to arrive at this conclusion in view of the money and effort expended and because of the implications for any future efforts by the federal government to deliver quality health care to low-income groups.

PERSPECTIVES ON PREVENTIVE HEALTH CARE POLICY FOR CHILDREN

Current Legislation

CHAP: Is It the Panacea?

The Children's Health Assessment Program (CHAP) was introduced by President Carter as an alternative to EPSDT in April 1977 (Health Care for Children, 1977). The legislation was under consideration during the 94th and 95th congressional sessions (from April 25, 1977 to October 15, 1978) but it was never enacted. In the Senate, the measure never reached the floor for a vote due to parliamentary maneuvering by the Republican Senator from Nebraska Carl Curtis[5] (Weiss, 1978). In the House, CHAP was debated briefly but was never brought up for a vote. So, despite vigorous lobbying by such groups as the Children's Defense Fund and the American Medical Association (Weiss, 1978), the congressional sponsorship and support needed to pass the bill was not present. According to Weiss (1978), supporters of CHAP seem optimistic that legislation similar to CHAP will be introduced in 1979. To date, however, this has not occured.

The CHAP legislation (S. 1392, 95th Congress) was designed to replace EPSDT, and some of its provisions specifically address EPSDT shortcomings. A discussion of the proposed changes will be presented here. Concerning federal reimbursement to states for carrying out the program, the average payment to states would be raised from 55% to 75% (Health Care for Children, 1977), increasing the incentive for states to identify all eligible children and provide needed follow-up care without taxing states' budgets. Concerning eligibility, the criteria would be expanded to allow children from low-income homes where the father is present (which formerly resulted in ineligibility) to be eligible for CHAP's preventive services. Continuity of care would also

be better assured since CHAP provisions would call for continuation of care to children for six months after the family's eligibility has been terminated (Health Care for Children, 1977). A fourth provision of CHAP concerns comprehensiveness of services provided by an agency. As the situation currently exists, services are located within several different agencies in a community, often causing a delay between detection of a possible problem by screening and subsequent diagnosis and treatment (Health Care for Children, 1977). The CHAP legislation would require that "... assessments be performed through comprehensive (emphasis added) health care centers or primary-care physicians capable of delivering necessary follow-up care" (Health Care for Children, 1977, p. 791). Although some confusion or resistance in existing health and welfare agencies may result, the change to health care centers should increase continuity of care and decrease agency fragmentation. However, a requirement that private physicians perform screenings and carry out necessary treatment is most likely not a feasible alternative for children from low-income families. (For a discussion of the problems associated with providing medical care through the private sector for families relying on public reimbursement programs, see the preceding section on Problems of EPSDT in Design, Developmental Assessment, pp. 14-23).

Additional provisions of the CHAP legislation include (from Health Care for Children, 1977):

(1) increased federal payment to states for administrative expenses, as an incentive for states to meet program goals and standards,

(2) a requirement that all children in the program receive immunization against childhood diseases. Provision of immunizations is a service offered by the existing EPSDT program, but it has been ineffectual in reaching the eligible population (Health Care for Children, 1977).

A raise in level of funding was also proposed for the CHAP program. The proposed funding level varied from a low of $263 million as proposed by Carter in his 1979 budget to a medium figure of $375 million for the Senate

bill to a high of $798 million for the House plan (Wehr & Gest, 1978). All were above the current funding level for EPSDT.

Former HEW Secretary Califano considered the funding increase an important aspect of the program because it would increase states' incentive to expand services to reach needy children (Health Care for Children, 1977). There is no doubt that increased funding would be welcomed by states, but there can be no assurance that funding itself would alleviate program ineptness. Some of EPSDT's problems are due to issues beyond the scope of funding increases (for example, issues relating to procedure and instruments for developmental assessment; lack of parental involvement and trust). To address these problems adequately, basic changes in program design and philosophy seem needed.

It is difficult to determine whether CHAP will meet with any more success than EPSDT did since the specific regulations and guidelines for implementation are not yet available. Most of the changes associated with the CHAP program speak directly to shortcomings of EPSDT, indicating a responsibility in legislation. Yet, the changes are only minor when the more fundamental shortcomings of EPSDT are considered. What seems to be missing in the CHAP legislation is the needed change in orientation to a truly preventive, truly comprehensive program. As with EPSDT, little attention seems to have been paid to the design of the CHAP program and to the methodology for its implementation. Until such basic issues are addressed, the potential of CHAP to become the panacea for the ills of EPSDT is doubtful.

Implications of National Health Insurance

A more recent development in the health care arena is the move toward national health insurance. Although the several programs currently under governmental consideration do not address children or poor children directly, their potential impact on children's health programs needs to be considered.

As of July, 1979, three national health insurance programs were under governmental consideration (Wehr, 1979b): one proposed by President Carter, a second by Senator Kennedy (D-Mass.), and a third by Senator Long (D-La.). Senator Long's plan is the only one that has been formally introduced as legislation (S 351). The three plans differ quite widely in scope. Long's plan is limited to "catastrophic" coverage (i.e., federal coverage of an individual's medical expenses and hospitalization above a certain "catastrophic" level) (Wehr, 1979c; 1979d). Carter and Kennedy favor more comprehensive plans which would affect not only payment mechanisms but federal regulations for private insurance companies and federal control of health services and distribution of resources (such as, hospitals, clinics, and practitioners) (Wehr, 1979a; 1979c; 1979d; 1979e). Informal negotiations during the past few months have resulted in concessions by the sponsors of the various plans, lessening the differences between them. Senator Ribicoff (D-Conn.) has been predicting a Long-Kennedy-administration compromise health bill later this year (Wehr, 1979d).

All three programs seem to share a common purpose, that of reducing health care costs for the consumer, but their programs vary in scope. Concerning provisions for needy groups, for example the poor, the programs differ widely. Long's bill, with its limited scope, makes no provisions for needy groups. Under this plan, it is not clear whether the Medicaid/Medicare structures would remain intact. Both Carter's and Kennedy's plan include provisions for comprehensive care for needy groups, although Kennedy's more ambitious plan would not only maintain existing federal health care plans but also improve them. The specific improvements to be made are not yet specified.

Both the Carter and the Kennedy plans should be praised for their statements of support for special health services for the needy groups. However, the specific

ways that each of these programs will meet these needs (in particular, the needs of the poor), have not yet been specified. There are a number of important questions that any federal health care program for the poor, especially poor children, should address. These questions address scope of the program, quality and distribution of services, financing mechanisms, and eligibility:

Scope	What types of services would be included? Only diagnostic and treatment services in the case of illness? Would preventive services, such as screening, be included? Would prenatal services be provided? How would information about the type of services and eligibility be disseminated? Would there be outreach services? Would a health education component be included? Would mental health services be provided? What services would be included under the rubric of mental health?
Quality and Distribution of Services	Would there be federal control over the quality of services provided? Would assurances be made for equal distribution of services--i.e., hospitals, personnel, health-care equipment, clinics?
Financing Mechanisms	Would the federal government carry all responsibility for financing the program? What share would tax-payers contribute? Would the eligible poor pay any percent of the cost?
Eligibility	Would eligibility requirements be flexible enough to include functionally-poor groups such as the working poor, or families with medical bills which reduce them to poverty level?

The passage of national health insurance, a seemingly inevitable occurence, represents a crossroads for health care in the U.S. This action has the potential to raise the quality of health care available to the average citizen to an unprecedented high level. It is of utmost importance that the needs of the poor not be overlooked in the process. Programs and provisions that are geared toward poor children, for remedial as well as preventive care, must become a priority.

Recommendations for Future Policy

A major question that health care policy-makers will want answered is: What should our policy on health care for poor children be? Foremost, a change in general program orientation is recommended--from a program which is chiefly secondary prevention to one that places strong emphasis on primary prevention. Of course, remedial or therapeutic services cannot be eliminated. Early detection and appropriate intervention are still needed to belay the negative effects of a physical or mental health problem. The chief focus, however, should be provision of primary prevention services to help reduce the incidence of physical and mental illness, while promoting good physical and mental health.

A primary prevention program has as its main purpose the prevention of the occurence of disease or illness. Broadly defined, such a program would include not only disease prevention but the prevention of handicapping conditions, mental health disorders and developmental disabilities. Services provided by the program would expand beyond regular health care to include community outreach and education, especially prenatal and pre-parenting education. Specific recommendations for these are discussed below.

General Guidelines

A number of guidelines, addressing major characteristics of a primary prevention program for children, can be offered for the design of such a program. These include:

- community-based — Representatives of client groups and of local agencies administering the program should be involved in determining the physical set-up of the program, personnel, and types/numbers of services. A major criticism of EPSDT was its lack of responsiveness to community needs. Inclusion of community representatives in the planning stages will better insure positive acceptance of the program and high levels of participation.

·comprehensive	The scope of services provided should be broad, including the screening and diagnostic services currently offered by EPSDT along with expanded outreach and educational services. Existing community agencies and institutions (such as Public Health Service clinics, schools, and community mental health centers) can provide these services with a central agency supplying the administrative coordination.
·competency-orientation	Services should strive to highlight a child's health, and especially mental health strengths, as well as detecting weaknesses. This guideline, most applicable to developmental assessment, would require that only instruments which are culturally, racially, and linguistically appropriate should be used for assessments. Attention should be paid to cultural standards for or differences in behavior when assessing.

Specific Recommendations

In addition to these general guidelines, a number of more specific questions need to be addressed in the formulation of a primary prevention health care program for children. Listed below are these questions; recommendations for their solution follow.

1. What is the scope of a primary prevention health care program? What types of services should be provided? What ages should be served?

   As previously stated, the major focus would be prevention of physical and mental illness, and the promotion of good physical and mental health. Specific services to be provided would include:

   (a) Physical health services--diagnosis, treatment, and routine, periodic screening for diseases

   (b) Mental health services--diagnosis and treatment for mental health problems, such as behavior disorders or psychopathology

   (c) Developmental assessment--using instruments that are appropriate to a child's racial, cultural and linguistic background. (A model for selection of developmental assessment instruments, which would assure sensitivity to sub-group differences while maintaining consistency in assessment is presented in Appendix A.) Moreover, in contrast to the Children's Defense Fund (1977) recommendation, policy-makers should not rely on routine pediatric examinations as the primary means for developmental assessment. Specific procedures must be built into a prevention program to insure that appropriate developmental assessment (including highlights of a child's strengths) occurs. Parents should be maximally involved in the assessment and any subsequent therapy or intervention.

(d) Outreach services--to help with identification of eligible families and children, and to inform families about the program's services and eligibility requirements. In addition, outreach workers can add continuity to the program by following-up families outside the medical setting (e.g., in homes or community centers) to check for client satisfaction and participation. An outreach worker could also act as a temporary child/family advocate when needed.

(3) Educational services--including community education concerning good health practices. The practices emphasized would be hygiene, nutrition, physical activity and recreation, and prenatal care. The educational services could take the form of, for example, adult education programs--focusing on family health and health care, or school-age programs--focusing on pre-parenting education and individual health care. Federally-funded programs, such as FEED at Indiana University, provide models and educational materials for pre-parent and child development training in public schools.

Concerning ages of children to be served by the program, the main thrust should be birth through 12 years of age. This covers the highest period of vulnerability for healthy development, while restricting the age range to a manageable size. (If early efforts are successful, policy-makers might want to expand the program to include the ages of 13 to 18 or 21.) The program must include a prenatal component since this period of development is one of high vulnerability.

2. How will the program be administered? Will administrative responsibility rest with local, state or federal agencies? How will it be financed?

A primary implication of the argument for a community-based program is that local community agencies be meaningfully involved in both program design and operation. Nevertheless, it is important that the federal government maintain some regulation over the scope and quality of services. Coordination of agencies involved in service delivery is an important issue (as evidenced by EPSDT's administrative shortcomings), at the community, state and federal levels. It is mandatory that administrative responsibility and procedures for inter-agency coordination be made explicit before attempts are made to implement a program.

The most logical, and perhaps the only feasible, way to finance a comprehensive health care prevention program is through the federal government, with states as the likely mediators with local communities. The current recommendations for financing national health insurance (such as, an employer payroll tax, a health-care windfall profits tax, or an individual wage-earned tax) might be used to finance prevention services.

3. Will there be requirements for accessibility of services to target client groups, distribution of resources, and utilization of professionals/paraprofessionals from the communities to be served?

Since acceptance and participation by eligible families was a problem for EPSDT, it is important that future programs make special efforts to increase participation by target client groups. Services need to be accessible, physically and psychologically. The health caregivers and outreach workers need to be perceived by target families as trustworthy and sensitive to

their needs. Target families want health caregivers who speak their language and know their culture. To facilitate this, a training component should be included to train community members for professional and paraprofessional positions in health care. In addition, health services and resources need to be distributed fairly among urban, suburban, and rural communities.

Eligibility criteria should be flexible enough to include functionally-poor groups such as the working poor, or families with medical bills which reduce them to poverty level.

4. How will the success of a primary prevention health care program for poor children be evaluated? How will improvements be made?

As with the other aspects of a good prevention program, a strong but realistic evaluation component needs to be included in the program design. Relying solely on cost-effectiveness analysis, as discussed by Rivlin (1971), is inappropriate for a multi-purpose, broad program, such as the one described here. Appropriate evaluation strategies might take the form of first, determining which aspects of the current EPSDT program are successful and building these into the new design, and secondly, implementing and monitoring several pilot versions of the new program in several representative locales. This would allow for weak points to be spotted before full nationwide implementation. On-going evaluation and monitoring on the program after full implementation will allow modifications to be made where needed.

To summarize, recommendations have been made for a community-based, comprehensive, preventive health care program for poor children which has the following components:

Direct Services:	health mental health/developmental review outreach education
Administrative Structure:	community-based services with strong inter-agency coordination federal financing and regulation of scope and quality of services states as mediators between federal and local levels high accessibility and responsiveness to client needs
Training:	grants-in-aid to institutions of higher education, private institutions and communities for professional and paraprofessional training of target community members
Evaluation:	evaluation of current EPSDT programs to identify successful aspects evaluation of pilot versions before nationwide implementation on-going evaluation after full implementation

In conclusion, it is not sufficient for policy-makers to concern themselves only with lowering the cost of health care through legislation which reduces health care costs to the consumer. Simply providing states with increased funds for administering health programs is also insufficient. This type of action does not guarantee quality of health care nor does it guarantee that all eligible children are receiving care with adequate continuity. It is time for policy-makers to legislate a comprehensive health care program for children that takes a strong preventive orientation and is geared toward the needs of our country's poor and minority children. Moreover, full attention must be paid to program design to insure that eligible children do, in fact, receive the health care that they need.

FOOTNOTES

[1]This provision was included in the proposed CHAP (Children's Health Assessment Plan) program--legislation that would have replaced EPSDT, under consideration during the 94th and 95th congressional sessions.

[2]These data represent the number of screenings performed each year, not the number of children screened. Although EPSDT does not call for more than one screening per year, it is possible that some children were screened more than once in a year.

[3]Gibson (1978) uses the terms Mexican-American and Chicano interchangeably.

[4]The CDF authors qualify this recommendation by adding that an instrument may be used if it has been approved by HEW to meet certain criteria (CDF, 1977, p. 180). This addition makes the CDF position somewhat ambiguous.

[5]The 3-day rule was in effect requiring 3 working days between the day a bill is released by committee and the day it is voted on. In the case of CHAP, the bill was released from the Finance Committee on October 12, leaving only one working day until October 15, the closing day of the session. Senator Curtis would not support the move to wave the time requirement (Weiss, 1978).

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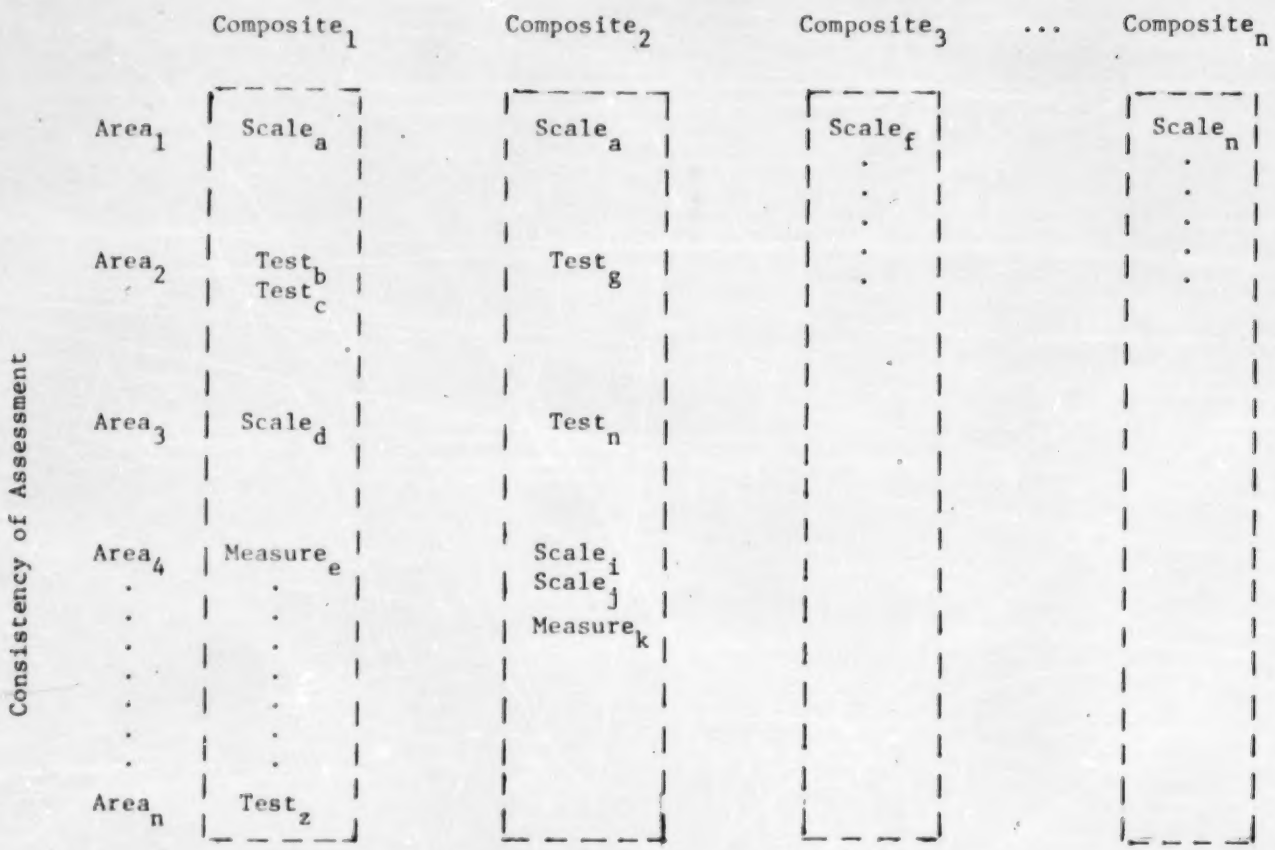
APPENDIX A

Sensitivity of Assessment



A schema for maintaining both consistency and sensitivity of developmental assessment for client groups with differing characteristics and needs is presented above. Definitions of terms are as follows:

Consistency of Assessment: All developmental areas are assessed in each composite. The specific abilities assessed and the measures used may vary for each composite.

Sensitivity of Assessment: Composites of developmental assessment measures, sensitive to key characteristics of various client groups (e.g., age, race, primary language, ethnic/cultural background), are used to insure appropriate assessment.